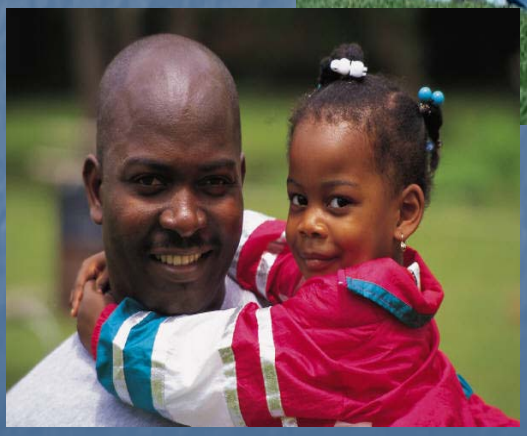
An Institute for Health Policy Studies, University of California, San Francisco report about The Healthy Families Program and the Seriously Emotionally Disturbed (SED) Carve-Out



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Introduction: Children up to age 18 with a seriously emotionally disturbed (SED) diagnosis are individuals who have difficulty functioning in schools, their family and/or the community due to mental illness. SED children enrolled in the Healthy Families Program (HFP) are to receive their SED treatment through county mental health departments rather than their health plan providers. Upon learning about a child with a SED condition (or a suspected SED condition), health plans are responsible for referring that child to the county mental health department for assessment and if appropriate, treatment. Estimated prevalence rates for active cases of SED vary widely and there is no standard or benchmark for an appropriate rate of SED referrals that, in turn, lead to an expected prevalence rate. Nonetheless, active cases reported by the county mental health departments of HFP children with SED appear to be lower than the lowest prevalence estimates, suggesting that in the HFP children may not be receiving appropriate mental health services.

The Problem: The HFP SED carve-out was created to ensure that children with SED conditions receive comprehensive, culturally competent treatment. However,

- The system is extremely complex and requires clear communication and coordination between health plans and counties involving numerous individuals, as well as an understanding about the system by primary care providers and families, all of which does not always occur.
- The design of the carve out and the monitoring system also do not account for multiple referral sources to counties or the relatively high proportion of parents and caregivers who choose to maintain their children with health plan mental health providers or with school services.
- Compounding these issues is the diminishing financial resources of counties, limiting many counties' ability to provide timely assessments and treatment.

These various factors result in inaccurate information about the number of SED HFP children referred to county mental health services and the extent to which HFP children with SED are receiving treatment in counties, as well as added administrative costs to health plans and counties for tracking and monitoring SED cases, and, ultimately, some children not receiving timely treatment.

What the HFP Cannot Change: Many of the factors which contribute to lower than expected SED referrals to and active cases in county mental health departments are not within the control of the HFP. The limited resources available in counties and some parents' choice of health plan providers, for example, cannot be addressed by the HFP (though MRMIB can promote use of MHSA funds to address childhood mental health personnel shortfalls in counties for underserved populations and preventive services). The relatively vague definition of SED contained in the California Welfare and Institutions Code compared to other carve-outs, such as

California Children's Services (CCS), likely contributes to lower than expected referrals to the extent that determination of whether a child is eligible for referral and use of county mental health services is open to interpretation. This, too, is not easily resolved by the HFP since there is no clearly delineated definition of SED in medical texts and other state and federal statutes.

What the HFP Can Change: There are specific steps that the HFP can take to clarify roles and responsibilities among the health plans and county mental health departments, promote coordination and communication between these partners, and more accurately monitor the extent to which HFP SED children are receiving needed care. These efforts, listed below, should be conducted in conjunction with health plans and counties as well as the Department of Mental Health and the American Academy of Pediatrics. Communication also needs to be improved between primary care providers and the county mental health systems about individual children in the county mental health system in order to assure appropriate treatment in both the primary care and county mental health settings. Specific recommendations include:

Carve-out Issues

- Create a statewide forum for increasing the understanding of health plans (local and central offices) and county mental health departments about issues related to referrals, assessment and treatment.
- Ensure that both county mental health departments and health plans have dedicated HFP SED liaisons.
- Maintain and regularly distribute current lists of these liaisons with reliable contact information. The responsibility for these lists should be centralized, probably at MRMIB.
- Create a communication and coordination link between county mental health providers and primary care providers to assure high quality care in both settings. Establish a central source for dispute resolution between the health plans and county mental health departments when there is a question about referrals, assessment and treatment.
- Clarify within the model MOU between health plans and counties which entity is responsible for services if the county capacity is insufficient to provide services and which entity is responsible for medications (and who pays).
- Engage the Department of Mental Health, the MHSA Oversight and Accountability Commission of the Mental Health Services Act and the American Academy of Pediatrics to develop strategies to improve services to children and strengthen continuity of care between health plans, behavioral health plans and county mental health departments to promote a coordinated system of care.
- Promote the use of the Mental Health Services Act funds to strengthen county mental health services for children with SED.

Primary Care Providers

- Emphasize the importance of early mental and behavioral health screening for all children and periodic repeat screening for high risk children through the currently available screening tools.
- Work collaboratively with the American Academy of Pediatrics Mental Health Task Force to incorporate the forthcoming revision of the Bright Futures to identify appropriate and easily administered instruments for mental health screening in primary care settings.
- Design and adopt easy to use referral systems for providers and families so that screened children who warrant health plan or county mental health department assessments have a clear path to the next step(s).
- Build the interagency collaboration necessary to have operationally efficient systems of referral and treatment and facilitate primary care providers' involvement in these systems, building a linkage between physical and mental health providers.

Parents and Caregivers

- More effectively communicate rights and responsibilities of HFP SED patients/parents recognizing the multiple demands on parents and the complexity of the system.

SED Data Collection and Reporting

- Give primary focus to monitoring the active SED cases collected and provided to HFP by the California Department of Mental Health.
- Consider requiring Kaiser Permanente to provide regular data reports on the number of Healthy Families children who are receiving mental health services for SED in the Kaiser system and on the number of referrals to mental health services for SED evaluation. This data can then be included in SED Status Reports and will provide HFP and the public a more comprehensive view of SED care provided through the HFP.
- Until Kaiser Permanente reports the number of Healthy Families children who are receiving SED services, adjust HFP SED reporting to report active case and referral rates that exclude the Kaiser Permanente enrollment volume, which Kaiser Permanente does not report.

Fundamentally, however, there is the need to better integrate prevention and treatment of mental health with physical health not just in the Healthy Families Program but in the health care delivery system in general. In the HFP and elsewhere, mental health services operate in a separate delivery system from physical health and are financed differently. Mental health is also typically treated as of secondary importance to physical health, in part due to stigma associated with mental health conditions, but also because it is not recognized as integral to overall health and well being. Addressing these issues in the context of the Healthy Families Program alone is nearly impossible, but engagements with the American Academy of Pediatrics, Medi-Cal, the Department of Mental Health, the health plans and counties and mental health professional organizations has the

potential to facilitate a more coordinated system of care within the child health community.

INTRODUCTION

Children up to age 18 with a seriously emotionally disturbed (SED) diagnosis are individuals who have difficulty functioning in schools, their family and/or the community due to mental illness. SED children enrolled in the Healthy Families Program (HFP) are to receive their SED treatment through county mental health departments rather than their health plan providers. Upon learning about a child with a SED condition (or a suspected SED condition), health plans are responsible for referring that child to the county mental health department for assessment and treatment, if appropriate. Estimated prevalence rates for active cases of SED vary widely and there is no standard or benchmark for an appropriate rate of SED referrals that, in turn, lead to an expected prevalence rate. However, referral rates and active case rates of HFP children with SED reported by county mental health departments appear to be lower than the lowest prevalence estimates, suggesting that in the HFP children may not be receiving appropriate mental health services.

How the System Is Designed To Work: The HFP uses two delivery systems to provide comprehensive mental health services to SED "classified" children enrolled in the program. (See Appendix 1 for the definition of SED.) The delivery systems include the health plans participating in the program (and in some cases, behavioral health plans) and county mental health departments. Participating health plans provide basic mental health services and medically necessary treatment of severe mental illnesses. Specifically, the health plan is responsible for:[1]

- The first 30 days of inpatient services or (with a maximum of 30 days of inpatient services per year);
- 20 outpatient visits for evaluation, crisis management, treatment of conditions that show benefit from relatively short- term treatment; and,
- Medications and lab services relevant to above.

Children suspected of being seriously emotionally disturbed (SED) by health plan providers are to be referred to the county mental health department for an SED assessment which is to be provided within 5 days of the referral for children hospitalized for a suspected SED condition and up to 30 days for children receiving outpatient mental health services through the health plan. With a confirmed SED classification, the county mental health department is supposed to provide (or

arrange) all outpatient and inpatient services beyond the first 30 days of inpatient care (for hospitalized children) for treatment of SED. There is no specification as to how soon treatment by the county mental health department is to commence.

To facilitate the coordination of care for HFP subscribers who are suspected of having a SED condition, the Managed Risk Medical Insurance Board (MRMIB) developed a model Memorandum of Understanding (MOU) (see Appendix 2) between the health plans and county mental health departments. The MOU defines the responsibilities of each party for the coordination of services for HFP enrollees.

This "carve-out" was designed to have health plans provide the basic services and the counties more expansive services for two reasons: (1) the policy makers believed the county mental health systems had the expertise, as well as the necessary networks of providers, and were better equipped to provide these services, particularly to children in the juvenile justice, child welfare and foster care system (the county mental health systems operate many of the programs that have established referral and coordination components and are tightly integrated with many of the referring entities; this applies especially to the children in the juvenile justice, child welfare and foster care system); and (2) the county mental health departments were providing services to many uninsured children and a carve-out provided counties with federal funds for services previously paid for out of general county funds.

Criteria for County Mental Health Treatment of HFP SED Children: SED is not a specific diagnosis but a legal term which triggers a host of mandated services. In California, SED is a term for classifying children who need services; although in other states and countries, there are varying definitions of SED. (See Appendix 1 for the California, federal government and other definitions.) The HFP is bound by the definition contained in the California Welfare and Institutions Code Section 5600.3(a)(2) which defines SED children and youth under age 18 who have a mental disorder as identified in the most recent edition of The Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the children's

age according to expected developmental norms. Specifically, children, including HFP subscribers, qualify for county mental health services if they meet the following conditions:

1. They have a mental impairment as identified in the most recent edition of The Diagnostic and Statistical Manual of Mental Disorders**;**
2. They do not have a primary drug or alcohol substance abuse problem or developmental disorder which results in behavior that is not normal for their age;
3. They have a problem in more than one of the following areas:
    a. Self-care
    b. School functioning
    c. Family relationships
    d. Ability to function in the community;
4. Either of the following exists as a result of the mental disorder:
    a. The child is at risk of removal from the home or has already been removed from the home, or
    b. The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment;
5. The child displays one of the following:
    a. Sees or hears things that are not there
    b. Has very unusual behavior
    c. Threatens or tries to hurt himself or others

Services County Mental Health Departments are to Provide to HFP SED Children: The following table outlines the continuum of services that are potentially available to Healthy Families children with a SED diagnosis.

Table 1. Continuum of Services Potentially Available in Counties for Healthy Families Subscribers with a SED Diagnosis

1. Outpatient Services
• *Day Treatment Services* provided in an organized and structured multi-disciplinary treatment program as an alternative to hospitalization to avoid placement in a more restrictive setting or to maintain the child in a community setting;
• *Mental Health Services*, including interventions designed to provide the maximum reduction of mental disability and restoration and enhanced self-sufficiency. This includes assessment, evaluation, therapy and rehabilitation[1];
• *Day Rehabilitation Services*, including evaluation and therapy to maintain or restore personal independence and functioning consistent with requirements for learning and development;
• *Crisis Intervention and Stabilization*. This is a service lasting less than 24 hours which may either be face-to-face or by telephone;
• *Medication Support Services* (prescribing, administration, dispensing and monitoring psychiatric medications necessary to alleviate the symptoms of mental illness.) The support does not include the actual cost of medication;
• *Case Management* to access medical, educational, social, vocational rehabilitative and other needed community services.
2. Inpatient Services in an acute psychiatric hospital or a distinct acute psychiatric part of a general hospital approved by the Department of Health Services to provide psychiatric services.
3. Partial Hospitalization, which is crisis residential treatment services and psychiatric health facility services.
4. Prescription Drugs

Source: Data Insights Report; Healthy Families Mental Health Utilization Report, 2004

[1] HFP Utilization Reports for the last three years, 2002-2005 show an average of 75% of the services billed by the county mental health departments are within this category.

***Purpose of This Study**:* As indicated in the Introduction, referral rates from health plans to counties for children with suspected SED appear to be low, suggesting that in the HFP children may not be accessing appropriate mental health services. The purpose of this report is to present findings from a study designed to examine whether mental health services are being underutilized by HFP children. Specifically, the study sought:

- To determine what accounts for low numbers and rates of referrals of HFP children suspected of SED from the health plans to county mental health departments;
- To determine what accounts for low numbers and rates of active cases of HFP children served in county mental health departments as reported to the Department of Mental Health;
- To evaluate whether coordination of referrals, assessment and treatment is adequately coordinated between health plans and county mental health departments; and,
- To identify recommendations to assure accountability, continuity of care, and access to quality services.

Study Methods: The evaluation methodology consisted of key informant interviews, interviews with parents of children enrolled in Healthy Families with a SED diagnosis and a review of utilization data in 10 counties: Fresno, Imperial, Kern, Los Angeles, Orange, Riverside, San Diego, San Francisco, Santa Barbara and Shasta. Key informants from county mental health departments (see Appendix 3), local and statewide health plans were interviewed. (Initially we planned to conduct focus groups of parents and caregivers of HFP children with a SED diagnosis, but due to extreme difficulties recruiting for the focus groups, 12 parents were interviewed by telephone.) In most of the counties, two staff members were interviewed including administration and front-line staff. Health plan staff knowledgeable about the SED referral processes for Healthy Families was also interviewed. These included individuals from the health plans' central offices as well as local health plan offices. Referral and active case data related to Healthy

Families enrollees with a SED condition were collected from MRMIB and the California Department of Mental Health (CDMH) and analyzed.

As part of this study, we also examined data prepared by MRMIB on the number of HFP subscribers who were referred by their health plan to county mental health departments for SED evaluation and treatment (if needed); and data collected by the California Department of Mental Health on the number of HFP SED active cases based on Department of Mental Health Short Doyle/Medi-Cal Claims. Both of these sets of data are published in annual "SED Status Reports" published from March 2002 (covering 2000 and 2001 fiscal years) through July 2006 (covering fiscal year 2003-2005).

An Advisory Committee was formed consisting of county mental health professionals, health plans, representatives from the California Mental Health Directors Association, advocates, a representative of the state health plan association, a researcher from the field of children with Special Health Care Needs, MRMIB and The California Endowment (TCE). (Members of the Advisory Committee are presented in Appendix 4.) The Advisory Committee provided guidance and feedback on specific counties to include, interview instruments and protocols, technical aspects of mental health issues in California, and distribution of our findings.

LOWER THAN EXPECTED SED REFERRALS AND ACTIVE CASES

SED Prevalence Estimates and Limitations

Estimates of the prevalence of SED vary significantly from 3% to a 26% (Table 2).[2] This wide range is attributed primarily to the lack of a single national standard definition of SED (see Appendix 1 for a review of the various definitions) and the methodological differences among studies in the definitions of SED, leading to difficulties measuring prevalence (and likely variations in assignment of diagnosis). Studies also vary in specification of terms of the duration of the condition and the level of functional impairment. Estimates may also be based on self-report surveys without prior diagnoses from a mental health professional.

[2] The HFP SED Status Report (March 2002) described national estimates of SED prevalence at 3-5%. The origin of this estimate is unexplained.

Table 2: SED Prevalence in the Literature

Prevalence	Population	Cited In	Primary Source
5-9%	Children ages 9-17	Mental Health: A Report of the Surgeon General, Ch.2 (Background Chapter)	Friedman, R. M., Katz-Levey, J. W., Manderschied, R. W., & Sondheimer, D. L. (1996b). Prevalence of serious emotional disturbance in children and adolescents. In R. W. Manderscheid & M. A. Sonnenschein (Eds.), *Mental Health, United States, 1996* (pp. 71–88). Rockville, MD: Center for Mental Health Services.
9-13%	Children ages 9-17	Mental Health: A Report of the Surgeon General, Ch.3 (Children and Mental Health)	Friedman, R. M., Katz-Leavy, J. W., Manderscheid, R. W., & Sondheimer, D. L. (1998). Prevalence of serious emotional disturbance in children and adolescents. An update. In R. W. Manderscheid & M. A. Sonnenschein (Eds.), *Mental health, United States, 1998* (pp. 110–112). Washington, DC: U.S. Government Printing Office http://www.mentalhealth.samhsa.gov/publications/allpubs/SMA99-3285/execsummary.asp
9-19% (in authors' review of the literature) 8.3 %* (from author's study) of children in the civilian, noninstitutionalized U.S. population were identified by the Disability Group criteria as having a mental/emotional problem and/or functional limitation	Children; depending on criteria used to establish diagnosis and functional limitation and the reference period (i.e., 3 months, versus 6 months or 1 year) * author notes that their prevalence estimate of 8.3% is probably low based on their criteria used for the study, criteria is determined by questions of children's emotional/cognitive development and	Mental Health, United States 2000,Ch. 19, Estimates of Mental and Emotional Problems, Functional Impairments, Associated Disabilities Outcomes for the US Child Population in Households	Friedman, R. M., Kutash, K., & Duchnowski, A. (1996). The population of concern: Defining the issues. In B. Stroul (Ed.), *Children's Mental Health, Creating Systems of Change* (pp. 69–96). Baltimore, MD: Brookes.

Table 2: SED Prevalence in the Literature

Prevalence	Population	Cited In	Primary Source
	functionality as reported by parents - data from the NHIS - on Disability 1994-6		
5-9%	School-age population	School Mental Health Services in the United States, 2002–2003 SAMHSA p.59	Cites Surgeon General Report U.S. Department of Health and Human Services. (1999). Mental health: *A report of the surgeon general (executive summary)*. Retrieved April 18, 2005, from www.surgeongeneral.gov/library/mentalhealth/summary.html. Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Mental Health Services; National Institutes of Health, National Institute of Mental Health.
5-9%	Of children (doesn't specify age)	New Freedom Commission on Mental Health, Achieving the Promise: Transforming Mental Health Care in America. Final Report.	United States Public Health Service Office of the Surgeon General (2001). Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service. Farmer, E. M. Z., Mustillo, S., Burns, B. J., & Costello, E. J. (2003). The epidemiology of mental health programs and service use in youth: Results from the Great Smoky Mountains Study. In M.H. Epstein, K. Kutash, & A. Duchnowsk (Eds.), Outcomes for Children and Youth with Behavioral and Emotional Disorders and Their Families: Programs and Evaluation Best Practices 2nd ed., [in press]
3-26%	Children with serious emotional/behavioral problems (Not SED exactly) – this range is based on the literature reviewed by the author and indicates the variability in methodology, purpose of study, etc.		Brauner, CB, Stephens, CB. Estimating the prevalence of early childhood serious emotional/behavioral disorders: challenges and recommendations. Public Health Reports May-June 2006; 121:303-310
4% to 8% of the study	9, 11, and 13 year-olds from		Costello EJ, Angold A, Burns BJ, Erkanli A, Stangl DK, Tweed DL The Great Smoky

Table 2: SED Prevalence in the Literature

Prevalence	Population	Cited In	Primary Source
population (depending on the type of impairment)	a predominantly rural area of North Carolina Def of SED for purpose of study "defined as a DSM-III-R diagnosis in the presence of impaired functioning in 1 or more areas"		Mountains Study of Youth. Functional impairment and serious emotional disturbance Arch Gen Psychiatry. 1996 Dec;53(12):1137-43

Low Reported Referral Rates and Active Case Rates

Despite the ambiguity about what the true SED prevalence is, active cases in counties of HFP enrollees are significantly lower than even the low end of the national estimates. (Referrals are also significantly lower than prevalence rates, but comparisons of referrals to prevalence are not useful since referrals don't necessarily correspond to a diagnosis.) For the 2001-2002 through the 2004 -2005 Benefit Years, the percent of children in the HFP referred by their health plans to county mental health departments for SED assessments ranged from .17 percent to .24 percent, with the rate in recent years decreasing slightly to .22 percent.

Table 3: HFP SED Referrals From Health Plans, Fiscal Years 2001-2005

	2000-01	2001-02	2002-03	2003-04	2004-05
Number of SED Referrals	1,098	942	1,616	1,538	1,638
SED referrals as % of all HFP subscribers	0.24%	0.17%	0.24%	0.23%	0.22%

Sources: Data Insights-SED Status Reports for Benefit Years 2001-2003; personal communication with Ruben Mejia, MRMIB, September 13, 2006; 2004 Healthy Families Program Mental Health Utilization Report.

For the 2001-2002 through 2004-2005 Benefit Years, the trend from active HFP cases (reported by the county mental health departments) showed an increase from .63 percent to .87 percent.

Table 4: HFP SED Active Cases Reported by Counties, Fiscal Years 2001-2005

	2000-01	2001-02	2002-03	2003-04	2004-05*
Number SED Active Cases	2,213	3,530	4,772	5,778	6,322
SED Active Cases as % of all HFP subscribers	0.48%	0.63%	0.72%	0.87%	0.85%

*Preliminary data provided by CDMH.
Sources: Data Insights-SED Status Reports for Benefit Years 2001-2003; personal communication with Ruben Mejia, MRMIB, September 13, 2006; 2004 Healthy Families Program Mental Health Utilization Report; personal communication with Daniel Nahoun, CDMH, May-June 2006.

(It is important to note that despite these low rates of referrals, the active cases rate has increased steadily over the past few years and the referral rate is averaging approximately .24 percent to .22 percent. See Appendix 5 for a detailed description of this.)

WHAT ACCOUNTS FOR LOWER-THAN-EXPECTED REFERRALS AND ACTIVE CASES?

Understanding the reasons for this is difficult because of the many players and the many conceivable (and sometimes demonstrated) factors. Our investigation reveals two general explanations: (1) underreporting of SED children being served and (2) significant issues with the design of the specialty mental health carve-out system. Added to this is the complexity of the system, the local variations in resources and the understandable confusion among those who must implement care in two programs for the same child.

Under Reporting

Kaiser Permanente Healthy Families Plan SED Children Reporting:

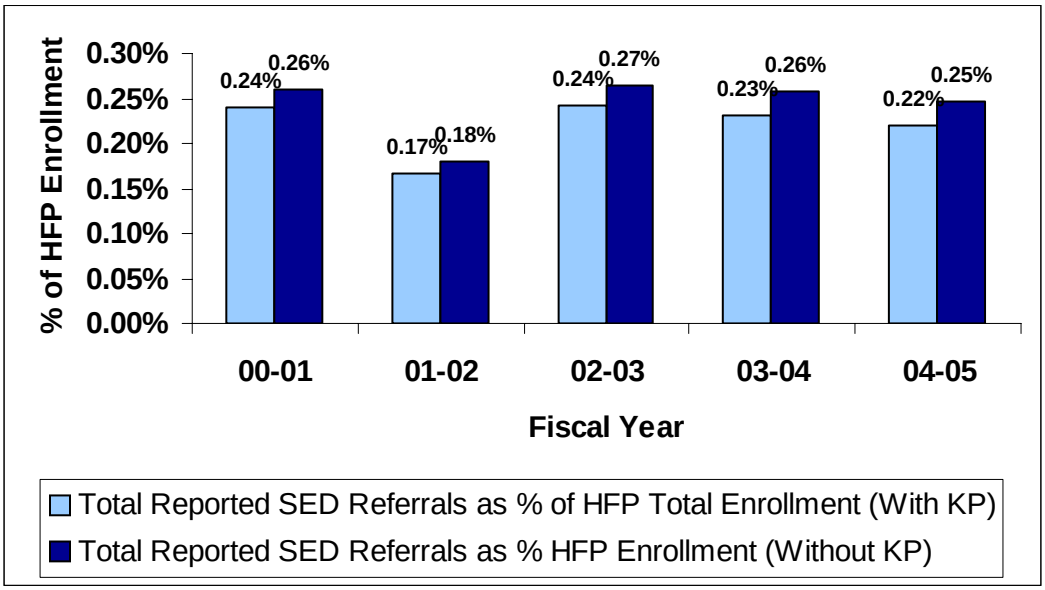
Unlike other health plans, Kaiser Permanente does not refer suspected SED cases to county mental health departments. In California, Kaiser Permanente has its own internal psychiatry departments to which it refers suspected HFP SED subscribers for both identification and treatment. In its June 2004 SED Status Report, HFP noted that "Kaiser Permanente has not been able to operationalize the referral of

HFP subscribers to county mental health departments." Because Kaiser Permanente does not typically use the county mental health departments for identification or treatment of its HFP SED children, there are virtually no referrals to counties and active cases do not appear in the HFP SED Status Reports. This cannot be interpreted to mean that HFP children who are Kaiser Permanente members do not obtain SED services; conversations with Kaiser Permanente psychiatry staff and representatives of other health plans indicate that Kaiser Permanente provides both evaluation and treatment to its HFP SED subscribers. (For the 2002-03 year, Kaiser Permanente did report to the HFP that a total of 2,300 of its 57,684 HFP subscribers (4%) were seen by a mental health clinician.) However, these data do not differentiate by the type of mental health services, so it is impossible to ascertain how many of these are SED cases.

Because Kaiser Permanente does not report SED-specific data to MRMIB or the Department of Mental Health, the number of referrals and active cases as a percentage of HFP total enrollments are understated. That is, in HFP reporting on those reports, no referrals and no active cases appear for Kaiser Permanente. Rates of referral and active cases are calculated by adding up the statewide number of the referrals and the number of active cases (separately), and dividing those sums by the HFP's total enrollment for the given year. Because Kaiser Permanente's population appears in the denominator of the rate, but its referrals and active cases do not appear in the numerator, the rates of referrals and active cases appear lower than they actually are.

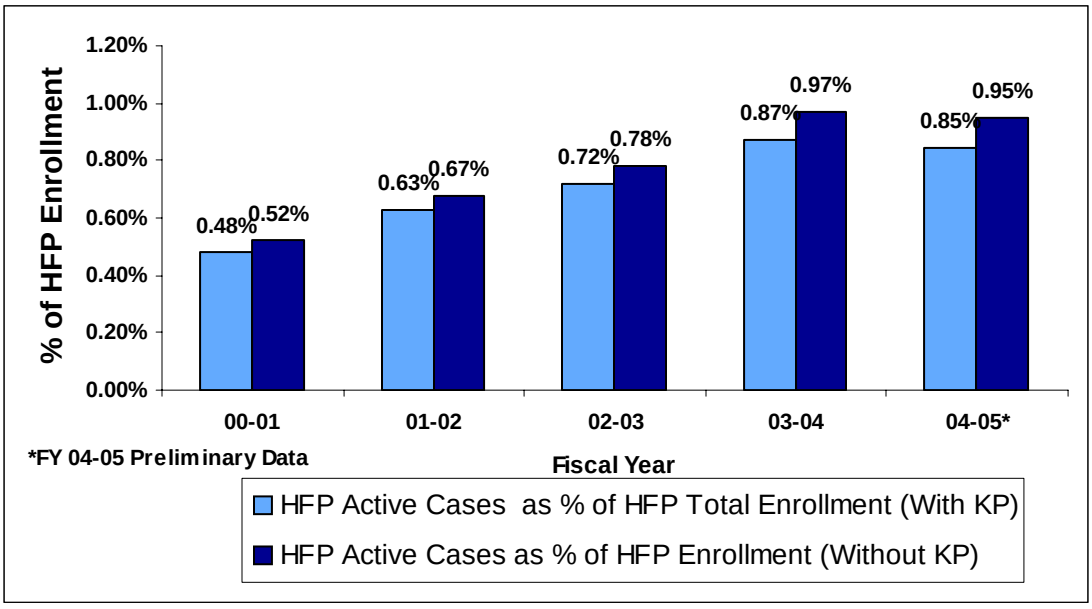
We have adjusted the calculations to show rates of utilization from all HFP plans that report referrals and active cases divided by the total number of HFP subscribers minus the number of Kaiser Permanente HFP subscribers in that year. (See Figures 1 and 2.)

Figure 1. SED HFP Referrals By Health Plans as a Percent of HFP Enrollment, Fiscal Years 2001-2005



Sources: Data Insights-SED Status Reports for Benefit Years 2001-2003; personal communication with Ruben Mejia, MRMIB, September 13, 2006; 2004 Healthy Families Program Mental Health Utilization Report.

Figure 2. Active HFP SED Cases Reported by Counties as a Percent of HFP Enrollment, Fiscal Years 2001- 2005



*Preliminary data provided by CDMH.
Sources: Data Insights-SED Status Reports for Benefit Years 2001-2003; personal communication with Ruben Mejia, MRMIB, September 13, 2006; 2004 Healthy Families Program Mental Health Utilization Report; personal communication with Daniel Nahoun, CDMH, May-June, 2006.

The impact of this change is small but is growing in importance because Kaiser Permanente's share of the total HFP enrollment has been increasing from 7.3% in 2000-01 to 11.0 percent in 2004-05. (Table 5)

Table 5: Kaiser Permanente Healthy Families Enrollees

	2000-01	2001-02	2002-03	2003-04	2004-05
Kaiser Healthy Families Enrollment	33,475	38,629	57,684	67,241	82,294
Total Healthy Families Enrollment	457,386	562,614	666,984	664,984	747,733
Kaiser Permanente Healthy Families Enrollment as % of Total Healthy Families enrollment	7.3%	6.9%	8.6%	10.1%	11.0%

Sources: Data Insights-SED Status Reports for Benefit Years 2001-2003; personal communication with Ruben Mejia, MRMIB, September 13, 2006; 2004 Healthy Families Program Mental Health Utilization Report.

In sum, the SED referral and active case rates are somewhat under reported due to this "Kaiser Permanente effect." A true estimate of SED referrals requires removing Kaiser Permanente from the denominator of all HFP subscribers in the calculation.

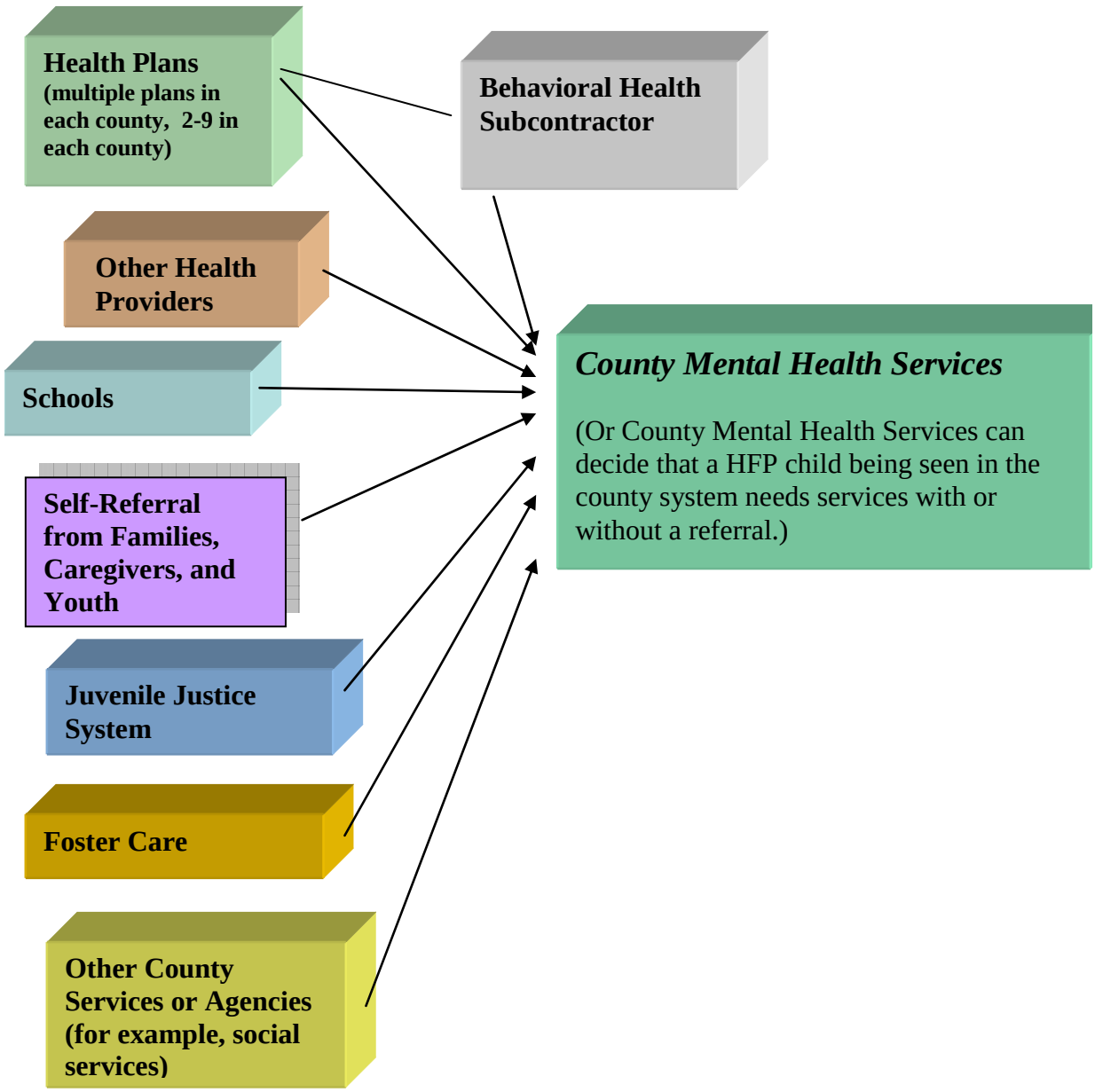
Multiple Sources of Referrals to Counties: Another likely source of underreporting is the fact that some HFP subscribers with SED are referred to county mental health department by non-health plan sources (unbeknownst to the health plan) and that counties serving these non-health plan-referred children may not be aware that that child has HFP coverage.

The HFP system for children with SED is designed for the health plans to make referrals to counties for assessment, but children are also referred from schools, juvenile justice, social services, child welfare, parents and caregivers. (Figure 3) When children are referred by non-health plan sources, two results can occur: (1) the health plan may not be aware that the child is actually receiving county mental health services, leading to the erroneous impression that the child is not being served, and, (2) the county mental health department may not know about the

child's enrollment in the HFP unless information about the child's insurance status is requested. There appears to be wide variability among counties in terms of the extent to which insurance coverage is asked of new patients. If a child's HFP coverage is not known to the county mental health department, the program is not billed and the child is not reported to the California Department of Mental Health as an active HFP SED case.

Remedying these problems requires that county mental health departments: (a) uniformly inquire about health insurance coverage; (b) bill the HFP for appropriate children and report HFP SED cases to the state Department of Mental Health; and (c) and notify the health plans that they are serving these children so health plans (and health plan primary care providers) are aware of the mental health services that their members receive outside of the plan.

Figure 3. Potential Referring Organizations and Entities for SED HFP Children to County Mental Health Services



Challenges Presented by the Current Carve-Out System Design

Despite the likelihood that some HFP enrollees with a SED condition are in care but are underreported in the referral and active case figures, there are program design features that impede referrals to counties and appropriate utilization. A major contributing factor is the complexity of the carve-out referral system. There is also a lack of communication between and among some health plans and county mental health departments and an uneven understanding among local health plans as to the role the health plans' central office can play in resolving problems. Some county mental health departments and health plans are also uncertain as to which entity is responsible for treatment if the county mental health department lacks the resources or providers to do so immediately and where children should be served beyond the benefit year.

Complexity of the System: The carve-out process of referring a child from a health plan to county mental health services is complex and requires that the large number of players – health plans, mental health subcontracting behavioral health organizations, counties, schools, primary care providers and parents/care givers – adequately understand the policies and procedures and have the resources to carry them out. Though many we spoke to in each of these groups were knowledgeable, it is clear that understanding is inconsistent. Most county mental health administrators interviewed stated they have a clear system in place, including centralized intake in some counties, and health plans indicated that they were confident about their processes. However, most health plans and the counties also expressed concern that the other party lacked sufficient knowledge about how the referral process should operate.

The complexity of the system affects parents as well. One example of this is the fact that some children receive multiple assessments. While it is not technically a requirement that the health plan assess a child prior to making a referral to the county mental health services department, this is the mechanism for making an appropriate referral. Assessment of a child's psychiatric symptoms may need to become more detailed as he/she moves to a higher level of care, for example, to the specialty mental health carve-out portion of the care continuum.

However, unnecessary duplication of assessments may be discouraging and difficult for parents. Under the carve-out, most children receive two (and possibly three) assessments – first from health plan primary care providers (and possibly from the behavioral subcontracted plan) and then from the county mental health assessment provider. This is costly and can be problematic for parents because it can entail numerous, time consuming appointments. Perhaps more important, as children move from one system to the other, they must develop new relationships with providers. Several parents indicated that consistency with a provider was essential for their SED child and multiple assessments and the need to change providers is viewed as disruptive for children and counter productive to treatment. For these reasons, some parents of HFP children with suspected SED refuse the referrals to counties. MRMIB data from FY 04-05 indicate that 5% of parents across all health plans refuse to have their child suspected of SED conditions referred to county mental health departments. Anecdotal data suggest that this figure may be higher.

From another perspective, it is important to note two positive benefits of the HFP SED program carve-out to the county mental health departments: (1) these departments also administer the Medi-Cal mental health benefit so that when children's eligibility shifts between HFP and Medi-Cal – which is not uncommon as family incomes change -- continuity of care can be maintained within the county mental health department; and (2) the county mental health departments have considerably more infrastructure (such as case management and home-based services) to support specialty services such as SED.

***Out-of-Date Lists of Liaisons*:** Dedicated liaisons are needed to ensure and monitor referrals and assessments, to resolve problems when children do not receive necessary care and to maintain coordination between the health plans and the county mental health departments. Yet, health plans and county mental health departments are not always clear who the liaison in the other institution is or how to effectively communicate with them, in large part due to out-of-date lists of health plan and county mental health department liaisons. This results in confusion, inefficiencies, added costs and sometimes lost cases. One example of this relates

to the transfer of referrals from health plans to county mental health departments, which must be in writing and is usually faxed. In the absence of contact information for a current county mental health staff member who can receive the fax referral (and with whom the health plan can communicate to assure that the referral was received), substantial follow up is sometimes required. For the health plans and the county mental health services department, this results in a lack of efficiency and wasted resources. County mental health departments report similar problems when they are unclear who the current health plan SED liaison is. County mental health departments frequently need to contact health plans to obtain additional information about a referral and when the county mental health department is unclear about who to contact at the health plan, that information transfer occurs inefficiently and limited staff time is wasted.

MRMIB previously maintained a list of liaisons for counties and health plans, which was updated annually. Given staff turnover in counties and health plans, these lists are frequently out-of-date. Centralization of the maintenance and distribution of county mental health department and health plan liaison lists with MRMIB would be most efficient, but other entities could assume this role.

Local vs. Central Health Plan Problem Solving: Variation was found in the understanding and knowledge of the role that health plans' central offices can play in mediating conflicts and resolving problems. Each of the health plans with which we interviewed had dedicated staff in the central office to provide this role; however, several of the local offices of the same health plans reported that they were not aware that such an individual existed or that they could otherwise obtain assistance from the central office when an issue around referrals and assessment, benefits, or access to care emerged.

Despite this, the model Memorandum of Understanding (MOU) (Appendix 2) states that disputes are to be resolved at the local level, that an arbitration feature be established between plans and the counties, that health plans and counties have knowledge of each other's beneficiary complaint process and that timelines are consistent with Department of Managed Health Care/Department of Insurance

guidelines. There are defined mechanisms, therefore, for communication within plans and between plans and counties that are not always adhered to.

The Role of Behavioral Health Plans: Compounding this complexity for counties, health plans and parents, is the subcontracting by some private health plans to behavioral health plans to provide mental health services. Of the 21 health plans participating in the HFP, eight subcontract to behavioral health plans for mental health services. Subcontractors are used principally to expand the array of mental health services available to members, but also to contain costs to the primary health plans by shifting the financial risk to another entity for this specialty care. Those health plans which subcontract tend to be among the largest health plans, including Blue Cross of California, Blue Shield of California, and Health Net. (Health plans which do not subcontract to behavioral health plans either:

- Provide services through plan staff (two health plans);
- Refer to the county mental health departments for all mental health services (three health plans which are local initiatives); or Contract with private mental health providers (eight health plans).

When behavioral health plans are used, a child with a suspected SED condition is referred by the primary care provider to the behavioral health plan for assessment and treatment. If a HFP child is suspected of a SED diagnosis, it is the responsibility of the behavioral subcontractor to make the referral to the county mental health department.

Based on interviews with behavioral health plans, counties and parents, it appears that this additional step can create additional complexities and opportunities for system break-downs. For example, counties are not always knowledgeable about the role of behavioral subcontractors and often lack strong relationships with them. Similarly, while subcontractors appear to understand the circumstances under which a referral should take place, they may or may not identify themselves as a representative of a specific health plan or the child as a HFP subscriber. If this communication does not take place, HFP subscribers with a SED diagnosis can be in the county system but would not be identified appropriately, potentially contributing further to underreporting of referrals and

active cases. Perhaps more important, the use of behavioral subcontractors introduces another entity into the equation, additional paperwork and another "system" that creates the potential for discontinuity.

Lack of Clarity Regarding Which Entity is Ultimately Responsible: Successful referrals don't always translate into timely assessments and treatment when there are waiting lists for county mental health providers. Yet, waiting lists in counties for SED assessments and treatment are not uncommon, particularly if the services of child psychiatrist are needed. Interviews with health plans revealed that in some counties it is not uncommon that the assessment and treatment waiting lists can be days to months long. Such delays can create problems for families and health plans: children may not be receiving the comprehensive SED care county mental health departments can deliver and the health plans bear the financial responsibility for services and medications. Responsibility for SED mental health services in the event that the county mental health department lacks resources or providers is not specified in the MOU. When providers are not available to treat children in the county mental health system, some health plans continue to provide that care. (In fact, the HFP contract with health plans stipulates that the health plans are responsible for treatment until the county mental health department assumes responsibility. The model MOU between health plans and counties, however, doesn't address this issue.) Counties are obligated to provide SED services to the extent they have the resources, and health plans are obligated to provide services until the SED child is officially in treatment within the county mental health department.

Treatment Beyond the Benefit Year: HFP children are entitled to health plan services at the beginning of each benefit year. Many HFP children who are receiving treatment in the county mental health system require treatment beyond the benefit year. County mental health departments can – and should – keep children in their system to ensure continuity of care. However, we found inconsistency among counties and health plans as they addressed this issue. In some cases, children are reverted back to the health plan for the first 30 days of inpatient care at the beginning of the benefit year. This means that children are

moved from one provider to another, and potentially reverted back to the previous provider, likely adding to the complexity of the system of care and breaking continuity of care. While this is problematic for any health or mental health condition, it is especially difficult for SED children, for whom continuity is particularly important for recovery. Yet, some counties do maintain SED children in need of on-going care in their systems. However, in those counties where this does not exist, children experience an interruption in their care when their benefit year ends.

Table 6. HFP SED Program Design and Operational Issues

Overview of SED Design and Operational Issues

Health Plans

Design

If child appears to be SED, the health plan is to refer to the County Mental Health Services Department for assessment of SED and outpatient treatment. The health plan is to provide the first 30 days of inpatient services (some "tradeoffs" are allowed between types of services, e.g., inpatient, day treatment, day rehabilitation, etc.).

If child does not meet SED criteria, but is diagnosed with autism, anorexia nervosa, bipolar disorders, major depression disorder, obsessive-compulsive disorder or schizophrenia, the health plan is responsible for all services related to this condition (regardless of the duration of the condition) as a result of the Mental Health Parity law.

Operational Issues

Outpatient children may start treatment with the health plan, without the health plan identifying a child as needing to be screened for SED. The health plan may use all or most of their 20 visit allotment for mental health services prior to determining that a child needs to be assessed for SED. In this scenario, the child and family are "established" with one provider and need to reestablish relationships with another.

Hospitalized children are easily identified by health plan for referral to counties. If the child receives outpatient mental health services, it is the responsibility of the health plan or the behavioral health subcontractor to make the referral. (Not all HFP health plans utilize behavioral health subcontractors. Of the 21 HFP health plans, 8 subcontract to behavioral health plans for mental health services.) Referrals actually come from multiple sources (Figure 3). Counties must be aware that a referred child is a HFP subscriber in order to count the child as an active HFP SED case.

Referrals from the health plan to the county mental health services department

Design

Referrals from health plan to county: Outpatient assessments are to occur within 5 working days. Inpatient assessments within 24 hours according to the model MOU.

Operational Issues

Assessment issues:

- Child must be assessed by the county for SED eligibility.
- Some counties do not have adequate mental health providers for assessment and treatment. Waiting lists for both types of services exist in some counties.
- While a child is on the waiting list, the health plan is to continue to provide services and medications but this doesn't always occur.

Continuity issues:

A family must change from the health plan provider(s) to the county providers if the child is deemed eligible for SED services (unless they refuse the referral). Some plans report 40% refusal rates for referrals to counties.

Medication Issues:

County mental health departments must pay for SED HFP children's medications out of county resources. While these prescriptions are eligible for federal reimbursement, a mechanism is not currently in place for the counties to receive reimbursement from the HFP.[ϕ]

[ϕ] A working group, comprised of MRMIB, Department of Mental Health, and the Department of Health Services, is currently studying this issue and possible solutions. At this time, it appears that a possible solution is to design a system similar to the one used in the Medi-Cal managed care program for beneficiaries receiving services under the Medi-Cal specialty mental health services consolidation waiver program. This working group next meets in September 2006.

Table 6. HFP SED Program Design and Operational Issues

Overview of SED Design and Operational Issues
Schools
Design
Schools are required to provide mental health services to children in order to assure they can function in school.* There is no specific reference in the law to SED. *These requirements are usually referred to as Section 26.5 of the Government Code, or 3632 after the original legislation. (Original legislation AB 3632, Chapter 26.5; Revised currently as AB 2726, Chapter 654.) Additionally, these requirements are sometimes referred to as the Individual Educational Plan (IEP).
Operational Issues
• Some counties and school districts have more money to provide these services than others. (County funding for this program varies widely.) • Some schools alert counties and/or the health plans about service to HFP enrollees; others do not. • Some schools and counties check with parents to determine whether they are willing to have SED services billed through their existing insurance. One small rural county reported assisting families with selecting appropriate insurance policies in order to obtain coverage. • Among three of the larger California counties, two stated they do not have the resources to coordinate SED HFP services with the Section 26.5 Program. • Some parents choose to receive services through the school system and not through the health plan or county mental health department. Note: Students who receive SED services from the schools receive them from county mental health providers as mandated by state law (Chapter 26.5). The provision of services through the schools eliminates the co-payments due for services through the health plan. • Potential stigma related to receiving mental health services through either the health plans or the county mental health department.
Self-Referral
Design
Parents and youths can and do contact the county mental health department directly.
Operational Issues
There is no tracking system linking children back to the health plan or to a central registry that identifies them as HFP subscribers.
Juvenile Justice and Other Social Service Agencies
Design
A number of social service agencies refer SED children to county mental health services for assessment and treatment.
Operational Issues
There is no tracking system linking children back to the health plan or to a central registry that identifies them as HFP subscribers.

Insufficient County Resources

A major theme that emerged from our interviews is a lack of resources in some counties to provide the needed services, despite the dedication of many county mental health staff to ensure provision of comprehensive, high quality care to children. One example of this is the waiting lists (which can range from days to months) in some counties for children to receive the initial assessment and/or to

receive treatment upon a SED classification. In some counties the wait for an assessment, or treatment, is due, in part, to outdated lists of providers eligible to perform these tasks. There also is a paucity of providers in some counties. (In these cases, the health plans typically continue to provide services through their mental health networks.) Locating a provider to treat children can also take months. In one county, it was reported that there was a 1-year wait to see a psychiatrist to get prescriptions. While this may be an outlier, other health plans/counties indicated that the wait ranged from days to weeks long. In these cases, some counties effectively revert the child back to the health plan's psychiatrist to obtain services and prescriptions.

These issues are directly linked to the dire financial condition of county health systems (although a paucity of child psychiatrists is a problem in the private health care system, too, so privately insured children are also affected.) At a time when the number of the uninsured is on the rise, thereby increasing the demand on county health services, funding from the federal and state governments for these services is on the decline. Additionally, funds available to the counties for reimbursement of services associated with special education students under Section 26.5 (SB90 and AB3632) have also been reduced significantly due to state budgetary constraints. Meanwhile, local tax revenues have also declined, further reducing county health services funds. This is occurring at a time when the need for and the cost of providing health care is on the rise. These multiple financial demands on counties leads to staff reductions, staff turn over and diminished ability to provide care.

The Role of Primary Care Providers

In order for primary care providers to appropriately refer SED HFP children for health plan or county mental health services, they must be able to identify the child as having a potential mental health issue, know how to make the appropriate referral, and inform the health plan of the referral (if the referral is to the county mental health department). Most pediatricians are not trained specifically to identify SED children, but are competent to identify symptoms. However, an easy to use and efficient screening tool would greatly facilitate this identification of potential

mental health issues, which, in turn, would increase the identification of SED children for referrals to the county mental health services.

A variety of screening instruments are available to assess mental heath, behavioral, and developmental conditions. (Appendix 6 provides definitions, criteria, and descriptions of a sample of these screening tools.) Experts report that it is practical and appropriate for pediatric primary care providers to screen for social-emotional and behavioral problems that may be associated with a psychiatric diagnosis and that may result in a child being eligible for services for a SED condition as defined in the HFP SED carve-out, though there currently is no tool which specifically assesses for SED. A committee of the American Academy of Pediatrics' Mental Health Task Force is currently creating guidelines for pediatric primary care practitioners to improve childhood mental health screening and referral. These recommendations will be released within the next year, as will a revision of Bright Futures (a national health promotion initiative that links children, families, providers, and communities). (Lack of coordination of medications between primary care providers and mental health professionals is another issue that can create difficulties. Appendix 7 contains a brief description.)

Parents and Caregivers

Parents and caregivers properly have a role in their child's care and the systems developed should meet the child's and family's needs The carve-out requirement that HFP SED children change from their health plan mental health provider to a county mental health provider is perhaps the most important issue, according to the parents and others with whom we spoke. This change in providers is the result of the health plan responsibility for the first 20 visits of basic mental health services. The health plans may start providing mental health services to youths without realizing they need to be assessed for SED services by the county mental health services department. As the health plan provider gains a better understanding of the youth's issues, they may see the need for a SED referral to the county. Many parents are reluctant to disrupt treatment, particularly if their child has developed a relationship with the health plan provider. One parent commented, "I don't like having too many people involved because my daughter

needs consistency….Also, taking her to multiple places is burdensome on me because of the transportation but also on my daughter because she doesn't do well with transition and change." Some parents also elect to maintain services for their children in other settings, such as schools. "I'm very happy with the services the school provides," another parent said. "It's convenient because the therapist comes to the school and my child is familiar with the school. Consistency is also very important for my child."

None of the parents we spoke with stated that they were reluctant to use county mental health services because of stigma about using county services or concern about a lack of cultural competency among their providers, but health plan and county mental health interviewees indicated that they believed that these were barriers for some parents. However, the parents interviewed for this study were likely different from those with whom we could not interview, so conclusions cannot be drawn from this small sample about the role of stigma and perceptions of lack of cultural competency among county mental health providers as barriers to mental health services in counties. One county assessment worker in a rural county with an ethnically diverse population participated in several community education sessions on mental health. She reported back serious community fears about stigma including comments such as, "I'm not crazy," and fears of children being removed from their parents' home either due to mental health or immigration issues.

Some parents indicated that they also were unclear about the benefits and the processes for referral and treatment in the county. Although parents receive detailed information about the HFP benefit package at the time of enrollment and a letter from the health plan at the time of the referral, some parents said that they didn't fully understand what they were being told. "My son has so many appointments, I don't have time to read the materials they sent me," one parent remarked. Divorce can compound this problem when one parent receives the information and another does not. According to one parent, "My ex-husband receives the materials and doesn't share them with me. So I don't know what's going on." The policy of some counties to revert a child back to the health plan at

the end of the benefit year is also confusing to many parents and interrupts – again – the continuity of care. (Not all counties operate this way, however. In some counties, children remain in the county mental health system throughout their treatment.)

It's important to note, however, that some parents are very pleased with the services their children receive through the counties. One parent commented, "I think that I've been very satisfied with the services that she [the daughter] has received, to the credit of our mental health department. I think it has been seamless." Another said, "I'm very satisfied with the service there. They treat you well there. I have not had any negative experience there up to now. They gave me the appointment with the therapist right away which is good because I was really desperate because of my son."

THE MENTAL HEALTH SERVICES ACT

The passage of Proposition 63 in 2004 led to the enactment of the Mental Health Services Act (MHSA). The terms of the Act specify that the new funding should be used for new, innovative services and not to supplant or back-fill services that should be provided with existing funding. Each county has developed a Community Services and Support plan to utilize these funds. A review of plans from the 10 counties in this study indicate that none have specifically proposed expansion of mental health services to HFP children, or HFP SED children, specifically. (This many not be surprising since many counties have focused on expanding services to populations currently not receiving services and HFP SED have access to at least some care in most counties. Counties could, however, still use these funds to expand the provider network for HFP children with SED conditions (as well as other mental health conditions) and strengthen their ability to process referrals and ensure timely assessments.

The MHSA also includes a Prevention and Early Intervention component. When it is fully implemented, it could augment the capacity of county mental health departments to serve children at risk of or with emerging mental health disorders. Currently, mental health programs are limited to tertiary prevention (that is, interventions that prevent a mental illness from becoming more disabling and

protracted). Use of the MHSA to serve SED children within the HFP would need to be carefully crafted to meet the specifications of the Act and could fall under the rubric of expanding prevention-oriented services or expanding these services to underserved populations.

CONCLUSIONS

The HFP SED carve-out was created to ensure that children with SED conditions receive comprehensive, culturally competent treatment. However, the system is extremely complex and requires clear communication and coordination among health plans, the behavioral health plans when they have subcontracts, and counties. Effective use of the carve-out also requires that primary care providers and families understand how the complex system works. The design of the carve out and the monitoring system do not account for multiple referral sources to counties or the relatively high proportion of parents and caregivers who prefer to maintain their children with health plan mental health providers or with school services. Compounding these issues is the diminishing financial resources of counties, limiting many counties' ability to provide timely assessments and treatment. These various factors result in inaccurate information about the number of SED HFP children referred to county mental health services and the extent to which HFP children with SED are receiving treatment in counties, as well as added administrative costs to health plans and counties for tracking and monitoring SED cases, and, ultimately, some children not receiving timely treatment.

RECOMMENDATIONS

Many of the factors which contribute to lower than expected SED referrals to and active cases in county mental health departments are not within the control of the HFP. The limited resources available in counties and some parents' preference for health plan providers, for example, cannot be addressed by the HFP (though MRMIB can promote use of MHSA funds to address childhood mental health personnel shortfalls in counties for underserved populations and preventive services).

The relatively vague definition of SED contained in the California Welfare and Institutions Code compared to other carve-outs, such as California Children's

Services (CCS), likely contributes to lower than expected referrals to the extent that determination of whether a child is eligible for referral and use of county mental health services is open to interpretation. This, too, is not easily resolved by the HFP since there is no clearly delineated definition of SED in medical texts and other state and federal statues. (As noted previously, the California statute defining SED is in Appendix 1.)

However, there are specific steps that the HFP can take to clarify roles and responsibilities, promote coordination and communication and more accurately monitor the extent to which HFP SED children are receiving needed care. The HFP should also continue to focus on ways to get more HFP subscribers with SED into treatment by partnering with health plans and counties to develop ways to increase appropriate use of the HFP SED care benefit as well as monitoring and reporting SED referrals and active cases. Additional partners should include the Department of Mental Health and the American Academy of Pediatrics. Communication also needs to be improved between primary care providers and the county mental health systems about individual children in the county mental health system in order to assure appropriate treatment in both the primary care and county mental health settings. Specific recommendations below relate to the design of the carve-out, primary care providers, communication with parents and care givers and data collection and analysis.

Fundamentally, however, there is the need to better integrate prevention and treatment of mental health with physical health not just in the Healthy Families Program but in the health care delivery system in general. In the HFP and elsewhere, mental health services operate in a separate delivery system from physical health and are financed differently. Mental health is also typically treated as of secondary importance to physical health, in part due to stigma associated with mental health conditions, but also because it is not recognized as integral to overall health and well being. Addressing these issues in the context of the Healthy Families Program alone is nearly impossible, but engagements with the American Academy of Pediatrics, Medi-Cal, the Department of Mental Health, the health plans and counties and mental health professional organizations has the

potential to facilitate a more coordinated system of care within the child health community.

Carve-Out Design

- Create a statewide forum for increasing the understanding of health plans (local and central offices) and county mental health departments about issues related to referrals, assessment and treatment. Topics should include: the HPF mental health benefit; roles and responsibilities of county mental health departments and health plans; the referral protocol; the timeframe within which assessments are to be completed and treatment is to commence; policies regarding where treatment should be provided at the end of the benefit year; the need for dedicated liaisons within each entity; the need for and value of close communication. Additional topics for health plans: the role that health plans' central offices can play in mediating conflicts and resolving problems related to referrals and assessment, benefits, and access to care. Additional topics for county mental health departments include: the importance of regularly inquiring about health insurance coverage (for children who are referred by sources other than a health plan), billing the HFP, as appropriate, and reporting HFP SED cases to the California Department of Mental Health.
- Ensure that both county mental health departments and health plans have dedicated HFP SED liaisons.
- Maintain and regularly distribute current lists of these liaisons with reliable contact information. The responsibility for these lists should be centralized, probably at MRMIB.
- Create a communication and coordination link between county mental health providers and primary care providers to assure high quality care in both settings. Primary care providers need to be informed about a confirmed SED diagnosis, be aware of treatment plans, including medications received through the county mental health department, treatment goals and progress. County mental health providers need to be aware of other health conditions, treatments and medications that have bearing on the SED treatment. Creation of this communication link should likely be established by the health plan.

- Establish a central source for dispute resolution between the health plans and county mental health departments when there is a question about referrals, assessment and treatment.
- Clarify within the model MOU between health plans and counties which entity is responsible for services if the county capacity is insufficient to provide services and which entity is responsible for medications (and who pays).
- Engage the Department of Mental Health, the MHSA Oversight and Accountability Commission of the Mental Health Services Act and the American Academy of Pediatrics to develop strategies to improve services to children and strengthen continuity of care between health plans, behavioral health plans and county mental health departments to promote a coordinated system of care. Given the extent to which children move between Healthy Families and Medi-Cal, it is important to involve Medi-Cal in these discussions to create uniformity in the mental health policies and procedures affecting low income children.
- Continue assessing design issues for HFP medication issues with the working group, comprised of MRMIB, Department of Mental Health, and the Department of Health Services members, to design solutions to the problem of counties not having a billing mechanism to be reimbursed for SED HFP medications.
- Support the use of the MHSA funds to strengthen county mental health services for children and transition-age youth, including HFP enrollees with SED.

Primary Care Providers

- Emphasize the importance of early mental and behavioral health screening for all children and periodic repeat screening for high risk children through the currently available screening tools. (However, because currently available tools do not screen specifically for SED, providers need to screen for mental health issues and refer these children, as appropriate, for general mental health assessments, which would, in turn, assist in identifying SED children.) Potential instruments include the Pediatrics Symptom Checklist, the Strengths and Difficulties Questionnaire, and the Eyberg Child Behavior Inventory.

Disseminate these, or similar, instruments and train primary care providers and school personnel to use them. Coordinate these trainings with the American Academy of Pediatrics and other professional pediatric, mental health, and educational associations.

- Work collaboratively with the American Academy of Pediatrics Mental Health Task Force to incorporate the forthcoming revision of the Bright Futures to identify appropriate and easily administered instruments for mental health screening in primary care settings.
- Design and adopt easy to use referral systems for providers and families so that screened children who warrant health plan or county mental health department assessments have a clear path to the next step.
- Build the interagency collaboration necessary to have operationally efficient systems of referral and treatment and facilitate primary care providers' involvement in these systems. Ideally, these systems would include multiple public and private insurance coverage systems so that providers can develop skills and learn protocols that apply across multiple programs. These programmatic issues are critical to define the policy options that will lead to a continuum of care in mental health services and between physical and mental health providers.

Parents and Caregivers

- More effectively communicate rights and responsibilities of HFP SED patients/parents recognizing the multiple demands on parents and the complexity of the system.

SED Data Collection and Reporting

- Give primary focus to monitoring the active SED cases collected and provided to HFP by the California Department of Mental Health. The active cases data show the number of HFP SED children receiving treatment by the county mental health departments. The number of SED active cases as a percentage of all HFP subscribers is a good indicator of the program's success in serving HFP SED kids with appropriate mental health services.

- Continue to track and report the number of referrals from health plans to county mental health departments so as to monitor trends in referrals and health plans' involvement in SED identification and treatment. Note, however, that health plan SED referrals to counties comprise part but not all of referrals because Healthy Families subscribers are referred to the county by a number of other sources.
- Consider requiring Kaiser Permanente to provide regular data reports on the number of Healthy Families children who are receiving mental health services for SED in the Kaiser system and on the number of referrals to mental health services for SED evaluation. This data can then be included in SED Status Reports and will provide HFP and the public a more comprehensive view of SED care provided through the HFP.
- If the above recommendation is not adopted (or until it is adopted), adjust HFP SED data to report active case and referral rates that exclude the Kaiser Permanente enrollment volume, which Kaiser Permanente does not report.

Future Research

The scope of this study was limited to examining SED referrals to counties and active cases. In the course of this work, a number of additional issues were raised which were not addressed but have significant implications for HFP subscribers' access to mental health services which require research. These include (but are not limited to):

- Table 1 above outlines the services that are to be available to HFP SED children by county mental health departments. Are these services actually available and are children receiving them?
- How can primary care structure of practice issues which can impede effective screenings (such as variability in capability to early identify children with mental health issues, lack time available to screen, and inadequate reimbursement) be addressed? (The American Academy of Pediatrics work group on screening instruments is reviewing these issues. A next step is to assess their work as it relates to the HFP

- To what extent are schools providing mental health services to HFP SED subscribers? What is the quality of that care? How are medications provided and funded?
- What are the issues (and solutions) related to medications for SED children prescribed by a mental health professional and those prescribed by other practitioners treating SED, mental health, or physical health? How can coordination between the various providers be improved?
- What are parents' views of the HFP benefits and the carve-out?
- To what extent are parents who refuse referrals to county mental health departments affected by stigma associated with mental health services versus using county services and/or concern about discontinuity of care?

Appendix 1. SED and SMI Definitions

SED (Serious Emotional Disturbance)	
Definition	***Source***
5600.3. (a) (1) Seriously emotionally disturbed children or adolescents. (2) For the purposes of this part, "seriously emotionally disturbed children or adolescents" means minors under the age of 18 years who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. Members of this target population shall meet one or more of the following criteria: (A) As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur: (i) The child is at risk of removal from home or has already been removed from the home. (ii) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment. (B) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder. (C) The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.	***California Welfare and Institutions Code (WIC) Section 5600.3(a)(2)*** http://www.aroundthecapitol.com/code/code.html?sec=wic&codesection=5600-5623.5
"The term serious emotional disturbance refers to a diagnosed mental health problem that substantially disrupts a child's ability to function socially, academically, and emotionally. It is not a formal DSM-IV diagnosis but rather a term that has been used both within states and at the Federal level to identify a population of children with significant functional impairment due to mental, emotional, and behavioral problems who have a high need for services. The official definition of children with serious emotional disturbance adopted by the Substance Abuse and Mental Health Services Administration is "persons from birth up to age 18 who currently or at any time during the past year had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the DSM-III-R, and that resulted in functional impairment	U.S. Department of Health and Human Services. (1999). Mental health: *A report of the surgeon general.* (Ch.3 Children's Mental Health)

which substantially interferes with or limits the child's role or functioning in family, school, or community activities" (SAMHSA, 1993, p. 29425). The term is used in a variety of Federal statutes in reference to children fitting that description and does not signify any particular diagnosis per se; rather, it is a legal term that triggers a host of mandated services to meet the needs of these children (see Service Delivery section)."	
"SED defined for the purpose of: Public Law 102-321, the Alcohol, Drug Abuse and Mental Health Administration Reorganization Act (1992), of which Title II establishes a block grant for community mental health services for children with severe emotional disturbance (SED). This law required the Center for Mental Health Services (CMHS) to establish the definitions for the term SED. The resulting definition of SED requires children to have a psychiatric diagnosis (excluding V codes, substance abuse, and developmental disorders occurring in the absence of another diagnosable disorder) and substantial impairment in family, school, or community activities. Adding an impairment indicator was meant to distinguish between children with psychiatric disorders that significantly affected their ability to function in their environment and those having only mild impairments." Note: V codes The V Codes are broadly divided into three groups. *Relational Problems* (such as marital or parent-child problems), *Problems Related to Abuse or Neglect* (such as spouse abuse or child neglect), *Additional Conditions* (such as an occupational problem or spiritual problem)	Mental health, United States, 2000 Washington, DC: U.S. Government Printing Office http://www.mentalhealth.samhsa.gov/publications/allpubs/SMA01-3537/chapter19.asp http://psyweb.com/Mdisord/DSM_IV/jsp/DSM_VCodes.jsp
"A serious emotional disturbance is defined as a mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified in the DSM-III-R that results in functional impairment that substantially interferes with or limits one or more major life activities in an individual up to 18 years of age. Examples of functional impairment that adversely affect educational performance include an inability to learn that cannot be explained by intellectual, sensory, or health factors; an inability to build or maintain satisfactory interpersonal relationships with peers and teachers; inappropriate types of behavior or feelings under normal circumstances; a general pervasive mood of unhappiness or depression; or a tendency to develop physical symptoms or fears associated with personal or school problems.*	Cited in New Freedom Final Report * Individuals with Disabilities Education Act (IDEA), Pub. L. No. 105-17. (1997).
'The CMHS definition is that children with "serious emotional disturbance" are persons: -From birth up to age 18 -Who currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM- III-R -That resulted in functional impairment, which substantially interferes with or limits the child's role or functioning in family, school, or community activities (p.29425)."	Federal Register. Vol. 58. No.96 Pages 29422-25 http://www.cdhs.state.co.us/dmh/de_pin_estimate_persons.htm#Definitions

SMI (Serious/Severe Mental Illness) **(***Used primarily for adults)*	
Public Law (P.L.) 102–321, the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) Reorganization Act, established a block grant for States to fund community mental health **services for adults with SMI**. The law required States to include incidence and prevalence estimates in their annual applications for block grant funds. The law also required SAMHSA to develop an operational definition of SMI and to establish an advisory group of technical experts to develop an estimation methodology based on this definition for use by the States. The definition of SMI stipulated in P.L. 102–321 requires the person to have at least one 12–month disorder, other than a substance use disorder, that met DSM-IV criteria (APA, 1994) and to have "serious impairment." A SAMHSA advisory group suggested that the term "serious impairment" be defined as impairment equivalent to a Global Assessment of Functioning (GAF) score of less than 60 (Endicott, Spitzer, Fleiss, & Cohen, 1976).	***SAMSHA*** http://oas.samhsa.gov/CoD/CoD.htm#1.2
"Serious Mental Illness" has been used to designate those individuals with conditions that are disabling,The Alcohol, Drug, and Mental Health Administration (ADAMHA) Block Grant formula is as follows: A committee of experts developed an operational definition of SMI. The definition is based on disorder and functional impairment. Respondents were defined as having functional impairment if their disorder substantially interfered with vocational capacity, created serious interpersonal difficulties, was associated with a suicide plan or attempt at some time during the past 12 months, or if the disorder met criteria for severe mental illness as operationalized by NIMH (includes diagnoses of schizophrenia, schizo-affective disorder, manic depressive disorder, autism, severe forms of major depression, panic disorder, or obsessive compulsive disorder, because these disorders are so severe that they almost always lead to serious impairment if not treated).	*http://www.infouse.com/disabilitydata/mentalhealth/appendices_glossary.php*
Serious mental illness includes:"…, adults with a serious mental illness are persons 18 years and older who, at any time during a given year, had a diagnosable mental, behavioral, or emotional disorder that met the criteria of DSM-III-R and … that has resulted in functional impairment which substantially interferes with or limits one or more major life activities…." The definition states that "adults who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are considered to have serious mental illnesses….DSM-III-R 'V' codes, substance use disorders, and developmental disorders are excluded from this definition…."	***DEPARTMENT OF HEALTH AND HUMAN SERVICES*** ***Substance Abuse and Mental Health Services Administration*** *Estimation Methodology for Adults With Serious Mental Illness (SMI)* *AGENCY: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, HHS.*

	Federal Register: June 24, 1999 (Volume 64, Number 121). Pages 33890-33897 Online via GPO Access [wais.access.gpo.gov][DO CID: fr24jn99-67] http://www.cdhs.state.co.us/dmh/de_pin_estimate_persons.htm#Definitions

Appendix 2. Model MOU

HEALTH PLAN MENTAL HEALTH DEPARTMENT MOU

This Memorandum of Understanding is designed as a template, addressing the major policy issues in the interaction between Healthy Families Insurance Plans (Plans) and County Mental Health Departments (Departments). The intent is to include major issues, while leaving scope within the MOU for development of specific procedures and agreements. The MOU is also designed to allow for individual decisions for specific beneficiaries and their needs. These issues will be decided on an individual basis between the Plan, the Department and the beneficiary, as needed.

This MOU is intended to apply to Plans that do not contract with the County Department to provide the basic Healthy Families mental health benefit. When the County Department also contracts with the Plan to provide the basic mental health benefit, an alternate MOU may be used.

TITLE	PLAN	DEPARTMENT
Referral Protocols	The Plan will obtain or arrange to obtain a mental health screening and assessment of any enrollee they suspect of being seriously emotionally disturbed. The Plan will then refer the child to the Department for evaluation if the Plan has reason to believe the following: A. The child is seriously emotionally disturbed as defined in WIC 5600 3 (attached). B. The disorder cannot be effectively managed with relatively short-term therapy. The referral for an evaluation shall be in writing and may include a locally agreed-upon referral packet that includes material the Plan and Department believe will facilitate timely, thorough referrals. The Plan may identify procedures for referral from primary care physicians.	The Department will assess or arrange to assess children referred for a mental health evaluation and will determine if the child/youth is seriously emotionally disturbed as defined in Welfare and Institutions Code 5600.3. The report on the evaluation shall be in writing. Evaluations will be completed within five days from referral for children already receiving inpatient services, and no later than 30 days from referral in all other cases, provided that all necessary information is included in the referral. Counties will be liable for inpatient costs incurred by the Plan when the child's discharge is delayed by county failure to meet these timelines. The Department shall develop a procedure for identifying Plan beneficiaries already receiving SED services.
Consultation/Care Coordination	Plan providers will be available to consult with the Department or its providers about beneficiaries that they both treat.	Department providers shall be available to consult with the Plan and its providers about beneficiaries they both treat.
	The Plan will develop a collaborative process to track and notify the Department when the 30 days inpatient benefit nears expiration. Specific timelines for notification will be arranged between the Plan and the Department.	Department crisis services providers will be available to the Plan and its providers to respond to urgent care needs.
	The Plan will notify the Department when any child previously determined to be seriously emotionally disturbed or likely to be determined seriously emotionally disturbed is admitted for inpatient care. This notification is for coordination purposes and is not a referral.	The Department will be involved in discharge planning for seriously emotionally disturbed children, at the request of the Plan.

TITLE	PLAN	DEPARTMENT
Consultation/Care Coordination, Continued	Procedures for accessing consultative services will be developed and may include general consultation on mental health and specialty mental health issues. Consultation may also include consultation on the need for physical health care evaluation and treatment.	Procedures for accessing consultative services will be developed and may include general consultation on mental health and specialty mental health issues. Consultation may also include consultation on the need for physical health care evaluation and treatment.
Medical Records/ Exchange of Information	When the Plan determines that a referral is likely, the Plan will request formal consent from the parent or guardian of a subscriber or from a subscriber under defined conditions of emancipation to share information with the Department as a part of the referral. The information to be shared will include: A. Medical and mental health conditions diagnosed by the Plan; B. Current medications prescribed by Plan providers C. All pertinent medical history. Treatment may be provided in emergencies as authorized in law. The Plan will share all information in accordance with federal and state regulations regarding confidentiality. The Plan will develop specific protocols dealing with sharing of information and substance abuse and HIV status. Methodologies for meeting all confidentiality laws and providing for medical information sharing between the primary care physician and the mental health practitioner to assure coordination and continuity of care will be collaboratively developed between the Plan and the Department.	The Department shall request formal consent from the parent or guardian of a subscriber or from a subscriber under defined conditions of emancipation who has been referred for evaluation or accepted for treatment to share relevant information with the Plan provider, including: A. The beneficiary's mental health condition. B. Current medications prescribed by the Department or its providers C. All pertinent medical history Treatment may be provided in emergencies as authorized by law. The Department will share all information in accordance with federal and state regulations regarding confidentiality. The Department will develop specific protocols dealing with sharing of information and substance abuse and HIV status. Methodologies for meeting all confidentiality laws and providing for medical information sharing between the primary care physician and the mental health practitioner to assure coordination and continuity of care will be collaboratively developed between the Plan and the Department.

TITLE	PLAN	DEPARTMENT
Provider Education	The Plan will work collaboratively with the Department to provide education and training to Department staff and providers regarding the Plan system, including authorization and referral processes and services provided.	The Plan will work collaboratively with the Department to provide education and training to Department staff and providers regarding the Plan system, including authorization and referral processes and services provided.
Plan Benefits for Seriously Emotionally Disturbed Children	Children being treated by the Department will retain eligibility for Plan benefits, including: A. Inpatient treatment of an acute phase of a mental health condition in a participating hospital for up to 30 days per benefit year as per benefits under this Plan, including professional and ancillary services associated with inpatient days. The Plan will provide inpatient services within the following parameters. The Plan will: A. When considering admission of SED children to an inpatient facility, utilize inpatient benefit approval criteria that are the same as Plan processes for inpatient benefit approval for non-SED HF children. B. Determine with the Department how ongoing care for SED children can be coordinated when inpatient services are required. C. The Plan, in consultation with the Department, will determine when non-patient care may be substituted for inpatient benefits to shorted inpatient stays.	Children accepted for treatment by the Department as seriously emotionally disturbed will be eligible for: A. Medically necessary outpatient services for treatment of the child's serious emotional disturbance. B. Medically necessary outpatient medication and laboratory services that are part of the child's outpatient Treatment Plan with the Department. C. Inpatient services including professional and ancillary services associated with inpatient days, when Plan inpatient benefits are exhausted and such services met Short-Doyle Medi-Cal medical necessity. The Department will: A. Consult with the Plan as they determine when non-patient care may be substituted for inpatient benefits to shorten inpatient stays. When the Department is responsible for inpatient care, it will utilize the Short-Doyle Medi-Cal medical necessity and emergency admission criteria for emergency admissions to an acute psychiatric hospital. (Attached)

TITLE	PLAN	DEPARTMENT
Dispute Resolution Process	The Plan and Department will develop a specific dispute resolution process that conforms to the following principles: A. Disputes are resolved at the local level. B. An arbitration feature is included. C. The Plan and the Department have knowledge of each other's beneficiary complaint process. D. Timelines are consistent with Department of Managed Health Care/Department of Insurance guidelines.	
	In the case of a dispute between the Plan and the Department involving a service, the Plan has responsibility to authorize, (i.e., inpatient with lab, prescription and professional services up to 30 days) the Department will provide benefits to the extent that the Department finds them medically necessary until the dispute is resolved. In the case of a dispute between the Plan and the Department involving a service the Department has responsibility to authorize (i.e., outpatient benefits with lab, pharmacy and professional services when a child has been determined by the Department to be seriously emotionally disturbed) the Plan will provide benefits to the extent that the Plan finds them medically necessary and within the Plan's benefit structure until the dispute is resolved. In the case of a dispute between the Plan and the Department involving the determination by the Department that the child is not seriously emotionally disturbed, the Plan will provide the benefits to the extent the Plan finds them medically necessary and within the Plan's benefit structure until the dispute is resolved. In the case of a dispute between the Plan and the Department involving the discharge of a child by the Plan from acute inpatient psychiatric services, the Department will provide benefits to the extent that the Department finds them medically necessary until the dispute is resolved.	
Liaison Function	The Plan will designate a mental health liaison to work with the Department on any issue relevant to this MOU.	The Department will designate a mental health liaison to work with the Plan on any issue relevant to this MOU.
Monitoring	Conduct periodic reviews, updates and renegotiations of the agreement as needed.	Conduct periodic reviews, updates and renegotiations of the agreements as needed.

Appendix 3. Individuals and Counties Interviewed

Fresno
Deputy Director/Quality Assurance Manager, Dept. of Children and Family Services

Director, Dept. of Children and Family Services

Imperial
Behavioral Health Senior Manager

Kern
Children's System of Care
Supervisor, Wrap Around Services & Juvenile Justice

Los Angeles
Medical Director for Children's Services
Department of Mental Health

Orange
Division Manager, Children and Youth Mental Health Services

Riverside
Program Manager, Children and Youth Mental Health Services

San Diego
Program Manager, Children and Youth Mental Health Services

San Francisco
San Francisco Community Behavioral Sciences – Mental Health Specialist

Santa Barbara
Children's Division Manager

Shasta
Clinical Program Coordinator

Appendix 4. Advisory Committee

TCE-MRMIB
Seriously Emotionally Disturbed (SED)-Healthy Families Study
Advisory Committee

William Arroyo, MD
Medical Director for Children's Services
Los Angeles County
Department of Mental Health
Los Angeles, CA

Ariella Birnbaum
Director, Regulatory Affairs
California Association of Health Plans
Sacramento, CA

Tanya Broder
Staff Attorney – Public Benefits
National Immigration Law Center
Oakland, CA

Leona Butler
CEO
Santa Clara Family Health Plan
Campbell, CA

Sai-Ling Chan-Sew
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Dept. of Public Health
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Jennifer Clancy
Executive Director
United Advocates for Children of California
Sacramento, CA 95815

Juno Duenas
Executive Director
Family Voices and Family Resources Center Network of California Support for Families of Children with Disabilities
San Francisco, CA

Brenda Kaplan
Blue Shield
San Francisco, CA

Vera Kennedy, CEO
Central California Children's Mental Health Foundation & National Mental Health Association of Greater Fresno
Fresno, CA

Don Kingdon Ph.D.
Mental Health Director
Shasta County Mental Health
Redding, CA

Jet Kruse, MFT
Deputy Mental Health Director
Eureka, CA

Peter Michael Miller, MD, MPH
Consultant
San Anselmo, CA

Janice Milligan, RN
Health Net- Public Health Coordination
Rancho Cordova, CA

Elisa Mullen
US Behavioral Health Plan, CA
San Diego, CA

Louise Rogers
San Mateo County Department of Mental Health
San Mateo, CA

Rhonda Sarnoff, DrPH
Research Associate
Children's Defense Fund-California
Oakland, CA

The California Endowment
Gwen Foster
Program Officer

Rosavignia Pangan
Program Associate

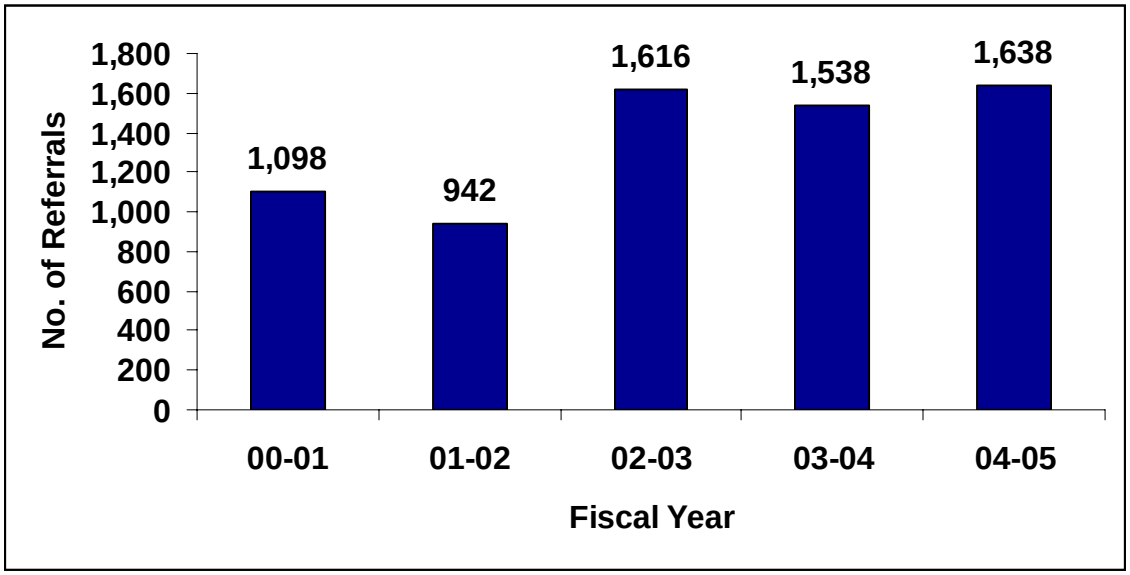
MRMIB
Vallita Lewis
Deputy Director
Benefits and Quality Monitoring

Ruben Mejia
Research Program Specialist

Appendix 5. Trends in Reported SED Referrals and Active Cases

Reported SED Referrals: The number of SED referrals increased from 2000-02 levels to the 2004-05 levels (Appendix Figure 1). Much of the overall growth in referrals came as a result of the substantial increase in the total number of HFP enrollees over that four-year period. The rate of referrals (number of referrals as a percent of total HFP enrollment excluding Kaiser Permanente enrollees) stayed quite stable across the 2000-2005 periods though it dropped somewhat in 2001-02 (see Figure 1).

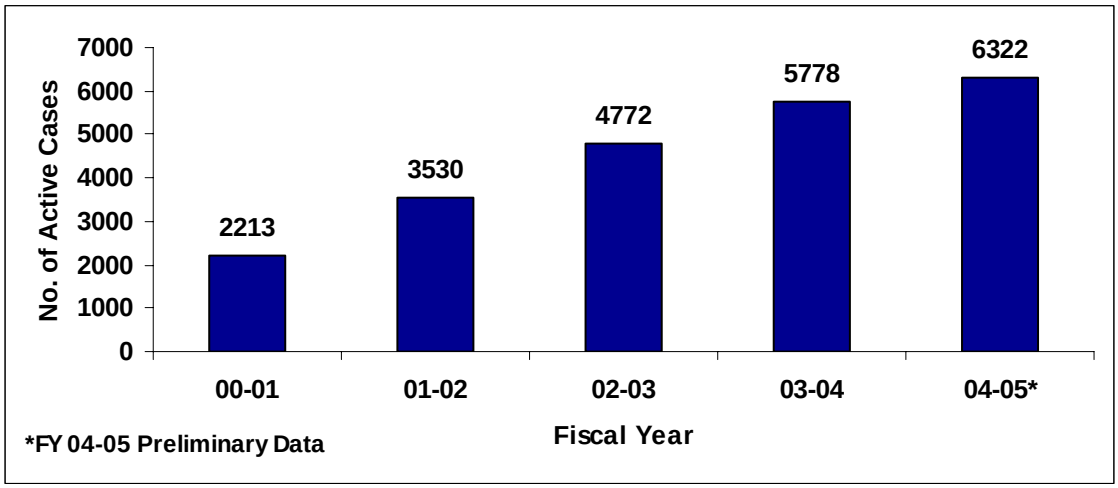
Appendix Figure 1. Number of SED Referrals in HFP, Fiscal Years 2001-2005



Sources: Data Insights-SED Status Reports for Benefit Years 2001-2003; personal communication with Ruben Mejia, MRMIB, September 13, 2006; 2004 Healthy Families Program Mental Health Utilization Report.

Reported SED Active Cases: As Appendix Figure 2 indicates, the number of HFP active SED cases (subscribers reported as receiving mental health treatment by counties for SED) has grown quite dramatically in recent years. In the three years from the 2000-01 to 2003-04 benefit years, the number of HFP SED active cases more than doubled (+153%). This is in significant part, but not entirely due, to the sizable growth in the overall number of Healthy Families' subscribers during the period.

Appendix Figure 2. Number of SED Active Cases in HFP, Fiscal Years 2001-2005



*Preliminary data provided by CDMH.
Sources: Data Insights-SED Status Reports for Benefit Years 2001-2003; 2004 Healthy Families Program Mental Health Utilization Report; personal communication with Daniel Nahoun, CDMH, May-June, 2006.

Active Cases FY 03-05

Among SED cases, both the number of active cases and the active case rates--the percentage of HFP subscribers receiving county mental health services for SED as a percentage of the total number of HFP subscribers (excluding Kaiser Permanente enrollees) in a given year--have increased substantially over the 2000-01 to 2004-05 period.

The SED active cases rate data is particularly significant because it demonstrates growth in HFP subscriber SED treatment beyond that accounted for by the relatively rapid increase in the number of HFP subscribers over this time period. The rate of active HFP SED cases as a share of total enrollment (excluding Kaiser Permanente subscribers) grew steadily from 0.52% in 2000-01 year to 0.97 % between 2003-04, nearly doubling in that 3-year period (+81%).

The increase in the proportion of HFP subscribers receiving care for SED is a positive sign that suggests counties' identification of HFP SED subscribers by counties, or the treatment rate of those subscribers identified as SED, or both, has improved over time. Moreover, these active case data probably undercount the number of HFP SED children receiving SED mental health services for the reasons cited in the report above.

On the other hand, there are other factors that may contribute to higher reported SED cases and rates:

- Increasing incidence of SED in the HFP population could account for a portion of the rise in SED treatment among HFP subscribers, and
- Better data capture and reporting by the counties and the Department of Mental Health could also be spurring the active case rates.

Despite the existence of factors that may increase or decrease the actual rate of SED treatment reported above, the active case total and the active case rates are probably the best measures to use in monitoring/evaluating the services provided to HFP SED children, because they address the key issue: are a sufficient number of Healthy Families subscribers needing SED treatment receiving those mental health services? The increasing rate of SED treatment among HFP children in recent years suggests that the Healthy Families Program's efforts to focus on SED treatment of subscribers are having an impact.

Appendix 6. Background Issues on Children's Mental Health Screening in Primary Care Settings

The tables below provide definitions, rationale for selection, and descriptions of a sample of the screening tools for mental health issues that might be used in primary care settings. As noted in the text the American Academy of Pediatrics will make recommendations on tools and training for primary care practitioners within the coming year.

Appendix Table 1. Screening Activities with definitions for use in creating an instrument for screening in primary care settings for mental health issues[2]

Terms	What it is	Who can do it	Effective implementation
SCREENING TOOL	Brief assessment procedure to identify children needing fuller diagnostic assessment	A person familiar with children or adolescents, and with the screening tool	Brief, easy to complete Questionnaire or interview Typically, designed to "over identify" children so that children in need of services are not missed.
ASSESSMENT TOOL	Procedure using standardized measure to answer particular diagnostic and developmental questions and develop information for treatment	A professional trained in the use of the instrument(s) e.g. developmental-behavioral pediatrician, psychologist, psychiatrist , special educator, language specialist, Master's level practitioners.	Testing should be directed to specific referral questions and results should be linked to an intervention plan. Child should be tested at a time when he can give his best performance.
DEVELOPMENTAL SURVEILLANCE	Ongoing, skilled observation of children during health visits	Trained professional	Elicit & attend to parent's concerns Collect relevant history Accurate, informative observations,

Terms	What it is	Who can do it	Effective implementation
			Communication with other professionals
EARLY DETECTION	Identify children at risk of, or with developing clinical problems	A person or professional familiar with the child	Tools include: Screening tests Professional elicitation of and interpretation of parent concerns
ANTICIPATORY GUIDANCE	Communicate to parent the expected developmental changes for the child	Trained professional e.g. pediatrician	Considers biomedical, developmental, behavioral, family, safety and supported interpersonal interaction
PREVENTIVE INTERVENTION	Early identification and intervention for maladaptive behavior so as to prevent psychiatric disorders	Person or professional trained to recognize, diagnose, and provide intervention	Prevention may be at 3 levels Universal (Primary) Selective (Secondary) Indicated (Tertiary)

Rationale for Choosing Mental Health Screening Tools for Primary Care Practices

In order to be useful, a tool needs to be broad enough to document relevant risk factors yet easy enough to administer and analyze so that it is efficient in the use of resources. Screening instruments for use in primary care settings should be:

- Brief to complete,
- Easy to administer, score, and interpret,
- Designed to be used in diverse settings, by a broad range of practitioners, with diverse backgrounds,
- Multifaceted, assessing developmental level and risk factors affecting social-emotional delays and disorders,
- Accurate in identifying children at higher risk of social-emotional delays or disorders, and
- Appropriate for use with ethnically and culturally diverse children and families, and with families who speak languages other than English.[3]

Appendix Table 2. Potential Instruments for Use in Screening Children and Youth for Mental Health Issues[4]

These instruments are cited as samples of instruments that are easy to administer (completed by parents, teachers, or youth); completed with paper and pencil; can be completed in the primary care practitioner's waiting room; and are designed to accurately identify (not miss) children with potential issues.

Domains and Tools	Age Range	Administered by/ Time required	Languages and/or Comments
Pediatrics Symptom Checklist	4-16 years 11-16 years	Paper and pencil or interview (Requires 5th grade reading skills.) For ages: toddler to 10: parent or caregiver completes. For ages 11- 16, youths complete self assessment. Scoring can be done by staff; Interpretation by practitioner with advanced training is recommended. 10 minutes	English, Spanish, Japanese
Strengths and Difficulties Questionnaire	3-16 age, and up to 25 years	Paper and pencil. Parents or teachers, Specific section for nursery school-aged parents or teachers. Self-administered section for youths aged 11-16 (depending on level of understanding and literacy) May be scored and interpreted by trained staff. 10 minutes	English, Spanish, Chinese, French, Japanese, Thai, Arabic, and many others (45 total)
Eyberg Child Behavior Inventory	2-16 years	Paper and pencil. (Requires 6th grade reading level.) 15 minutes. 5 minutes to administer, 5 minutes to score	English and numerous unofficial translations.

Appendix 7. Medications for SED Youths from Multiple Sources

Another problem, revealed through our interviews but unrelated to referrals and active case rates, is a lack of coordination between county mental health providers and the health plan primary care providers, whom HFP SED children continue to see while receiving mental health services from the county. Many SED children receive major medications to address their SED condition. They may also be medicated for other medical conditions. In the absence of coordination, there can be undocumented negative interactions between the various drugs. One parent said that she worries about her child's diabetes and that "the [SED] drugs affect his glucose levels somehow." Lack of coordination among county mental health providers and health plan primary care providers (and the health plans) has other consequences as well: diminished quality of care due to insufficient communication about the child's comprehensive treatment plan, potential duplication of services, possible elimination of needed services and increased costs.

Endnotes

[1] California Institute of Mental Health – Healthy Families Update January 2001,http://www.cimh.org/downloads/Healthyfam_update_jan01.doc

[2] Adapted from material provided by Penny Knapp, M.D., Medical Director, California Department of Mental Health

[3] Sosna, Todd, Mental Health Screening and Referral Capacity for Children 0-5, California Institute for Mental Health, 2005, p. 9.

[4] Sosna, Todd, individual communication and The Infant, Preschool, Family, Mental Health Initiative Compendium of Screening Tools for Early Childhood Socio-Emotional Development, California Institute for Mental Health, 2005. URL: downloaded September 7, 2006. http://www.cimh.org/downloads/The%20Infant,%20Preschool,%20Family,%20Mental%20Health%20Initiative%20Compendium%20of%20Screening%20Tools%20for%20Early%20Childhood%20Social-Emotional%20Deve.pdf